FATA

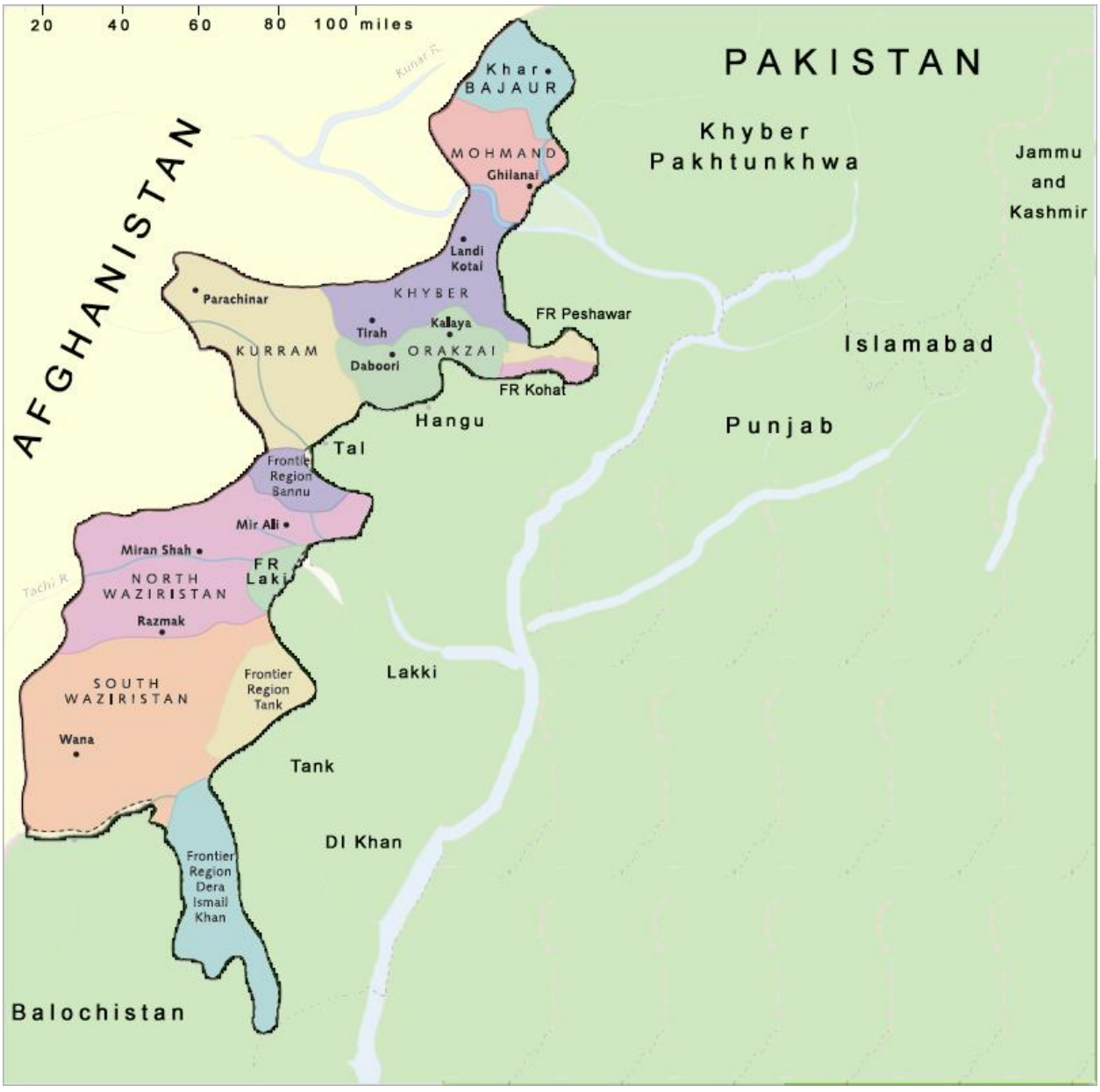
(Federally Administered Tribal Areas)

Regional RMNCAH&N Strategy (2016-2020)

National vision

for ten priority actions to address challenges of reproductive, maternal, newborn, child, adolescent health and nutrition

MAP OF FATA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CONTENTS

ACRONYMS

BHU	Basic Health Unit
CCT	Conditional Cash Transfer
CDK	Clean Delivery Kits
CMAM	Community-based Management of Acute Malnutrition
CMW	Community Midwife
CoIA	Commission on Information and Accountability (for Women & Children's health)
DDO	Drawing and Disbursement Officer
DHIS	District Health Information System
DHO	District Health Officer
DHQ	District Headquarter (Hospital)
DHRT	District Health Response Team
DoH	Department of Health
DOTS	Directly Observed Treatment Short-course
ENAP	Every Newborn Action Plan
ENC	Essential Newborn Care
EmONC	Emergency Obstetric & Newborn Care
EPI	Expanded Program on Immunization
FATA	Federally Administered Tribal Areas
FP	Family Planning
GIS	Geographic Information System
HCF	Health Care Facility
HCP	Health Care Provider
HIV	Human Immuno-virus
IMR	Infant Mortality Rate
IMNCI	Integrated Management of Newborn and Childhood Illnesses IRMNCAH&N Integrated Reproductive, Maternal, Newborn, Child & Adolescent Health and Nutrition
IUCD	Intra-Uterine Contraceptive Device
KPI	Key Performance Indicator
LHs	Lady Health Supervisor

LHV	Lady Health Visitor
LHW	Lady Health Workers
LMIS	Logistics Management and Information System
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MIS	Management Information System
MNCH	Maternal Neonatal and Child Health
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MNDSR	Maternal Neonatal Death Surveillance & Response
MPDSR	Maternal and Perinatal Death Surveillance and Reponse
MNH	Maternal and Newborn Health
MoH	Ministry of Health
M/oNHSR&C	Ministry of National Health Services, Regulation and Coordination
MPI	Multidimensional Poverty Index
MUAC	Mean Upper Arm Circumference
NMR	Neonatal Mortality Rate
NSC	Nutrition Stabilization Center
ODF	Open defecation free
OTP	Outpatient Therapeutic- Program
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
PHC	Primary Health Care
PHED	Public Health Engineering Department
PPIUCD	Post-Partum Intra-uterine Contraceptive Device
RHC	Rural Health Centre
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health Package
RTI	Reproductive Tract Infection
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
THQ	Taluka/Tehsil Headquarter (Hospital)

UNICEF	United Nations Children's Fund
UNFPA	United States Agency for International Development
WHO	World Health Organization

MESSAGE:

SECRETARY HEALTH, FATA

PREAMBLE

Pakistan is a country beset by several economic, social and cross border challenges compounded by repeated natural catastrophes and political instability. These factors are considered to have contributed to a vicious cycle of poverty and rapid population growth as well as a high rate of maternal and child mortality in the country. Communicable diseases, maternal & newborn health issues and under-nutrition dominate and constitute a major portion of the burden of disease in the country. Maternal deaths due to preventable causes like sepsis, hemorrhage and hypertensive crises are unacceptably high while in children, diarrhea and respiratory illness remain as the major causes of morbidity and mortality. Many of these conditions are controllable through relatively low cost interventions and best practices at the primary and secondary care levels.

Improving coverage for RMNCAH services is a high priority for the Government of Pakistan and the National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition, containing a list of ten priority actions, is a confirmation of the governments' commitment; made towards global movements and strategies such as 'A Promise Renewed' and "Every Woman Every Child" and is aligned with the overall National Health Strategy of Pakistan. The corresponding Action Plan at federal level also serves as a guide for all provinces and regions of Pakistan to formulate their own RMNCAH&N Action Plans. These consequent action plans have been developed through a process of detailed intradepartmental discourse and consensus in the four provinces and three regions of the country.

In order to ensure and sustain standard maternal, newborn and child health care services at all levels of health care, while keeping the principle of continuum of care in sight, the Department of Health' FATA MNCH Program - in coordination with the WHO, UNICEF and UNFPA - came up with a comprehensive five year Action Plan for the region in line with the "Ten Point Agenda" on RMNCAH and Nutrition 2016-2020 by the National Ministry for Health Services Coordination and Regulation. This Action Plan chalks out the activities needed in the region for betterment of the RMNCAH services through multi-sectorial approach in the light of the guiding principles in the National Ten Points Agenda elaborated in the document.

The development process was supervised and guided by the Secretary Health and Director General Health services FATA. Moreover, the costing of the Action Plan was done through consultation with the vertical programs of the region through a consultant hired for the purpose.

While FATA will endeavor to implement the plans through use of own resources, securing additional health care financing will be imperative to the success of this RMNCAH&N strategy as a medium term Investment Plan.

EXECUTIVE SUMMARY

In Pakistan, health care provision is traditionally the responsibility of the government. Under the 18th amendment to the constitution, the government has devolved a number of ministries to the regions including Health and Population Welfare. This provides the provinces and regions - including FATA, with opportunities for strategic planning as well as resource generation and management at the local level.

The poor health status is in part caused by insecurity & rampant militancy in FATA, poverty, low levels of education especially for women, low status of women due to strict cultural norms, inadequate sanitation and potable water facilities, low spending/expenditure on health even by Asian standards (0.9% of GDP in Pakistan as compared to 1.4%1; World Bank report). These factors combine to develop and exacerbate the prevailing conditions of inadequate and low quality primary health care services in the country. This has in turn put intense pressure on an already over-burdened health care system; leading to high rates of maternal and child mortality; especially so in the resource strapped areas such as FATA. Communicable diseases, maternal & newborn health issues and undernutrition dominate and constitute a major portion of the burden of disease in such cases.

Presently, in a reiteration of the commitment made towards global initiatives for addressing the key challenges in providing optimal care to mothers, adolescents and children, a comprehensive Strategic Action Plan - with identified priority areas - has been developed at federal level on the direction of the national leadership. It is in alignment to the National Vision for Coordinated Priority Actions to Address Challenges of Reproductive, Maternal, Newborn, Child & Adolescent Health, and Nutrition (RMNCAH&N). The same has also served as a guide for the formulation of the FATA RMNCAH&N strategic action plan.

The FATA RMNCAH&N strategy 2016 - 2020 builds on the vision of improving the health of women and children through universal access to affordable quality essential health services; delivered through a resilient and responsive health system aimed at attaining the Sustainable Development Goals and fulfilling other global health responsibilities of the country.

The FATA strategy follows the ten priority action areas; identified in the National vision, as its objectives and lays out a comprehensive 5-year plan of action for implementing and achieving the strategic objectives and expected outcomes through minute detailing of the activities to be undertaken at various levels of the FATA health care system

Core components of the strategy include:

a) Improving accessibility to quality primary health care at the community level by ensuring maximum coverage of rural areas, slums and other identified pockets of high need through induction of new community level health staff i.e. Lady Health Workers (LHWs) and Commu-

[1] http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS?end=2014&start=2014

nity Mid Wives (CMWs). Additional LHWs and CMWs will be recruited and equipped for the areas; left uncovered by existing health workers. Micro-nutrient supplementation as well as therapeutic treatment will also be provided for management of acute malnutrition among mothers and children under 5 years of age.

b) Improving quality of care at primary & secondary level care facilities will be achieved by enhancing the relevant knowledge base and skills of the different cadres of health care staff including, field staff such as LHWs, CMWs, LHVs, LHSs and other supervisory staff, Teaching and clinical staff such as midwifery tutors and clinical supervisors etc. Improving the referral system and provision of essential drugs, vaccines and equipment is also part of the strategy for effective and quality health care. To ensure availability of well furbished essential infrastructure for additional HR induction and capacity building, new midwifery schools, hostels and residences will be built.

c) Improving financial accessibility to reduce barriers to care seeking by the most vulnerable segments of the community will be achieved through developing forums for advocacy and orientation to politicians, policy makers and members of standing committees. Support groups for maternal and child health amongst the parliamentarians will also be established.

d) Health system strengthening will be achieved through expansion in essential health related infrastructure, provision of up-to-date equipment and latest technological enhancements to the health system. Construction and repair/renovation of essential infrastructure, vehicles and equipment and provision of comprehensive family planning services is a core theme. Strengthening referral linkages and feedback mechanisms are essential parts of the strategy.

   An integrated DHIS; incorporating RMNCAH&N indicators will enhance oversight and coordination between FATA and Agency management levels. Governance, oversight and accountability will be achieved through implementation of investigative and response mechanisms (MPDSR), development and implementation of accountability frameworks such as the oversight committee on RMNCAH&N and the Commission on Information and Accountability for Women & Children's health (CoIA), development and implementation of quality assurance tools (KPIs) and protocols as well as developing and linking of the M&E tools to these frameworks.

   Social mobilization and political will be achieved through advocacy seminars, symposium, international conferences and orientation sessions to raise awareness regarding RMNCAH&N interventions at regional and Agency level as well as SDGs amongst Politicians and the legislature. Health education interventions will be utilized to disseminate public health issues like family planning promotion and demand creation. Community based organizations, community elders, local influential, professionals, religious leaders etc. will be engaged using Volunteers and peer support groups for demand creation.

e) A Monitoring & Supervision framework will be developed including ToRs, plans, reporting formats and checklists at FATA, divisional, Agency and facility level. The overall responsibility of M&E will rest with the FATA Department of Health whereas the MNCH programs will be responsible for compiling their respective M&E reports on quarterly basis and submit regularly to the DOH to be consolidated on annual basis

The strategy also includes a detailed Financial Action Plan which serves as a resource mobilization tool which could be used comprehensively for mobilizing political commitment and financial resources at the national level or for garnering donor support.

The medium-term, RMNCAH&N strategy is aimed at reducing maternal, child and neonatal mortality through localized interventions and solutions that are culturally amenable as well as financially viable.

The accompanying action plan is designed to utilize existing resources and contributing towards achieving the SDG targets of Pakistan.

BACKGROUND

Pakistan is an agricultural country with 64% of its population living in rural areas.[2] Every year, approximately 476,000 children under five years of age die of preventable causes, and 14,000 women die from preventable complications related to pregnancy and childbirth[3]. These unacceptable deaths are potentially avoidable by ensuring that all women and children get the prevention, treatment and care they need. Access to reproductive, maternal, newborn, child health and nutrition services is a high priority need.

The Prime Minister of Pakistan, Mian Muhammad Nawaz Sharif, during a meeting in February 2015 with international and national leaders in public health expressed his concern over the slow progress in RMNCAH and nutrition related aspects in Pakistan over the last decades. He directed the national leadership to take stock of the situation and carve a comprehensive action plan with identified priority areas at national level taking along the counterparts and all partners in development sector addressing the key problems in a comprehensive manner. The Prime Minster of Pakistan reiterated that mother and child safety through proper immunization and better nutrition are also a major priority for the government. He further added that best practices should be replicated in Pakistan to achieve better results.

The corresponding Action Plan at federal level, developed on directions of the Prime Minister with ten priority areas, is a dynamic document and is leading to a mechanism for national consensus on important issues around RMNCAH and Nutrition. The objectives of the plan are also in line with global commitments for reproductive, maternal, newborn, child, and adolescent health such as the updated 'Global Strategy for Women's Children and Adolescent Health 2016 -30' and the SDGs. The 'Ten Point Agenda' was launched on 13th May, 2015 aiming to identify priority areas of health interventions that would enhance action for mothers and children of Pakistan.

Subsequently a consultative process was initiated between all stakeholders to identify priority areas and identify clear strategic directions for MNCH and Nutrition for the next ten years with tangible results/outcomes and a mechanism for oversight in order to ensure priority and visibility for the cause of mothers and children of the country.

[2] *PDHS 2012-13*

[3] *National vision for coordinated priority actions – RMNCAH Ten point agenda*

All provinces, regions, partners, line ministries, academics and international experts in Pakistan have contributed to and endorsed the action plan in order to take the process forward. The FATA Directorate of Health has been a keen participant in these consultations and has endorsed the National Vision wholeheartedly with the understanding that, collaboratively, FATA must:

1. Strengthen and invest in care during pregnancy, labor, birth, first day, week, year of life along continuum of care approach.
2. Improve quality of maternal, newborn and child care.
3. Reach every mother, newborn and child to reduce in equities.
4. Harness the power of parents, families and communities
5. Count every mother, newborn and child through measurement, program tracking and accountability

Consequently, FATA has developed concrete action plans to further operationalize the ten priority actions of the National Vision into a comprehensive strategy to serve the purpose of advocacy, resource mobilization and provide guidance in implementation during 2016-2020.

SITUATIONAL ANALYSIS

The Federally Administered Tribal Areas (FATA) has a population of roughly 3.18 million people[4]. Under the Constitution of Pakistan, FATA is included among the territories of Pakistan. It is governed primarily through the Frontier Crimes Regulation Act of 1901 and is administered by the Governor of the Khyber Pakhtunkhwa (KP) province in his capacity as an agent to the President of Pakistan while is under the overall supervision of the Ministry of States and Frontier Regions in Islamabad.

Table 1: Key Indicators of FATA

Total population	**3.176m**
Population – Urban	.85m
Annual growth rate	2.19
Adult literacy ratio (%) (2013-14)	33.3
Infant mortality rate/1,000 live births	86
Under 5 mortality rate/1,000 live births	104
Maternal mortality ratio/100,000 live births	380
%age delivered at home	72.6
%age delivered in hospitals / clinics	27.3
%age receiving antenatal care from a skilled provider	25.8
% Exclusive breastfeeding rate (0 – 6m)	21.2
% Children received 3rd dose of DPT	59

Sources: MICS FATA – 2009, Pakistan Demographics and Health Survey,(PDHS), 2006-2007, Population Census 1998, www.FATA .gov.pk

FATA constitutes 3.42% of the land mass of Pakistan and is populated mainly by people of Pashtun ethnicity; characterized by a very strong tribal structure and rich cultural heritage. There are about a dozen major tribes with several smaller tribes and sub-tribes. Administratively, FATA comprises of seven tribal agencies and six frontier regions demarcated along traditional tribal land-holding. The area is economically weak and, resultantly, the health status of the people as a whole is below the desired level. Moreover, 41.3 percent of the population use im-

[4] https://fata.gov.pk

proved drinking water sources while 28.1 percent of the population have access to improved sanitation facilities[5].

In FATA, the health care services are being provided by public and private sectors, however, the FATA Directorate of Health is considered by far to be the main provider of preventive care and a major provider of curative services in most of rural areas. The private sector is primarily a fee-for-service, highly fragmented and unregulated profit driven entity.

The FATA directorate of health is headed by a Director who manages the health services through Agency Surgeon in each agency. The directorate plans, executes, operates and maintains agency headquarter hospitals, civil hospitals, rural health centers, basic health units, dispensaries, clinics and health centers to offer basic health services to people, preventing the spread of diseases, ensuring a healthy and safe environment, maternal and child health and encouraging community participation in health services.

CHALLENGES & CONSTRAINTS

Continued insurgency and armed intervention in FATA has further deteriorated the health indicators in FATA. Due to continued security concerns there is a lack of skilled human resource in the area. Staff shortages and low retention is endemic in the entire FATA; particularly so amongst female staff employed in remote areas. This is identified as the biggest challenge for MNCH service delivery in FATA. The lack of trained staff is also a barrier to the provision of reproductive health and family planning services. Moreover, the logistical management information system (LMIS) needs to be strengthened for regular supply of medicines and contraceptives.

Furthermore, a major challenge towards providing health care is the restricted access to health services, especially for the poorer and more vulnerable segments of the population. These restrictions are physical, cultural (especially for females), administrative (staff availability) or financial (unofficial payments and opportunity costs). Uptake of modern health care practices such as institutional delivery and vaccination programs for children is also low due to traditional taboos and cultural norms of the people. Neonatal care is also not generally accepted, due to preferences for some cultural practices.

The health information system (DHIS) is available across all FATA, however, the data recording, reporting and follow-up feedback is not uniform. The major cause of delayed information is poor telecommunication, power failures and shortage of human resources at the facility level. There is lack of standardized monitoring and supervisory checklists for quality assurance in MNCH.

OPPORTUNITIES

The Directorate of Health FATA has been striving to promote a healthy society through a network of facilities and services. The community is already organized under tribal and clan affiliations. It has strong social support mechanisms already in place (clan loyalty) and thus a regular system exists for

[5] *MICS FATA 2007*

accessing the community. Moreover, the forum of *jirga* facilitates the sharing of ideas and solving problems. The area has relatively clean environment and is free from pollution and there is a growing awareness of health care and is strongly highlighted in public gatherings.

In response to the low availability of skilled workers in public health care facilities, the government has trained and deployed community mid-wives (CMWs) so that they can serve as an alternate to unskilled birth attendants (TBAs) in under-served and remote areas of FATA.

The salient features of FATA strategy are:

1. Focus on human resources for health in the area and provide opportunities for development of local human resources. This will be done through establishing paramedical schools and medical colleges in FATA.
2. Empowering the community to take actions for improving health. This is to be achieved by imparting knowledge to individuals, households, and communities.
3. The Health Management Information System will not only provide inputs in the policy formulation processes but also assist in monitoring and evaluation of ongoing programs and projects.
4. Necessary technical skills and support will be made available at various institutions to steer interventions.
5. Public private partnerships in health sector will be strengthened.
6. Economic uplift of the population is also important for overall health situation in FATA.

IMPLEMENTATION APPROACH FOR RMNCAH&N STRATEGY

The FATA RMNCAH&N strategy 2016 -2020 follows the vision and goal of the Action Plan for RMNCAH&N at federal level and pursues the ten priority action areas; identified in the national vision document, as its objectives to be achieved during the next five years.

VISION

To improve the health, particularly women and children, through universal access to affordable quality essential health services, and delivered through resilient and responsive health system, ready to attain Sustainable Development Goals and fulfill its other global health responsibilities.

GOAL

Provision of quality and affordable maternal, newborn, child, adolescent and nutrition health care in accountable and equitable manner through evidence based operational planning.

OBJECTIVE

1. Improving the access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural areas and peri-urban slums
2. Improved quality of care at primary and secondary level care facilities
3. Overcoming financial barriers to care seeking and uptake of interventions.
4. Increased funding and allocation for MNCH
5. Reproductive health including family planning
6. Investing in nutrition especially of adolescent girls, mothers and children.
7. Investing in addressing social determinants of health
8. Measurement and action at Agency level.
9. Accountability and oversight
10. Generation of the political will to support MNCH as a key priority within the sustainable development goals.

CORE COMPONENTS OF THE IMPLEMENTATION APPROACH

1: Improving accessibility:

An exercise of mapping will be carried out to identify uncovered areas of both CMWs and LHWs in FATA region. It will be ensured that 85% population are covered through LHWs and 100% population covered through CMWs in the targeted Agencies to provide outreach services by these community health workers; in a phased manner till 2020, especially in rural areas and urban slums of the region.

Additional LHWs and CMWs will be recruited for the areas; left uncovered by existing health workers in FATA region, to address the issues of access to RMNCAH&N services. The new recruits will also be provided with furniture, equipment, kits, CMW & LHW supplies, logistics and transportation cost to facilitate the establishment of CMW birthing station and LHW Health House.

Provision of comprehensive services for malnourished children at community level (CMAM, OTP) and Facility level through Nutrition Stabilization Centers (NSCs) is another focused area of intervention. Provision of micro nutrient supplements to the children, pregnant ladies; adolescents to overcome the nutritional deficiencies, address the exposure drug abuse among adolescents and awareness for health life style to deal with the long term health factors.

2: Capacity building

The technical teaching and clinical skills of additional midwifery tutors will be enhanced to impart quality midwifery training and LHSs will receive training in MDSR to contribute in preventing maternal deaths in their respective Agencies. The capacity building of pre-service training will focus on clinical, hands on skills and mandatory roaster for shift duties.

Emphasis will be laid on integration of IMNCI, PCPNC & ENC in pre-service education at medical schools to provide knowledge, develop skills and attitudes among students as part of their learning process and enable them to think through a differential diagnostic process before formulating a diagnosis and prescribing treatment. Similarly, in-service trainings for facility and community health workers will focus on topics like use of Chlorhexidine, use of Misoprostol, healthy timing and spacing of pregnancy (HTSP), essential newborn care (ENC), kangaroo mother care (KMC), Pregnancy, Childbirth, Postpartum and Neonatal Care (PCPNC), helping babies breathe (HBB), infant and young child feeding (IYCF) practices. Moreover, trainings on HIV/STI, TB, DOTS, Hepatitis, referral and reporting of MNC mortality, family planning methods: hormonal, long term FP methods, IUCD, PPIUCD, etc. will also be undertaken.

3: Improving financial accessibility & provision of safety nets

The strategy envisages developing forums for advocacy and orientation to politicians, policy makers and members of standing committees of the parliament on health and population issues through short in-session briefings on health programs to generate political will and ownership. Efforts will also be made to establish support groups for maternal and child health amongst the parliamentarians. These initiatives will be supplemented by conducting inter-FATA observational visits to highlight best practices and deepen learning and understanding regarding the issues and solutions there-of.

4: Health system strengthening

The strategy envisages expansion in essential health related infrastructure, provision of up-to-date equipment and latest technological enhancements to the health system for optimizing health care delivery. Residences for female health providers, new midwifery schools and hostels will be constructed and/or refurbished with necessary equipment and material to ensure availability of essential infrastructure for additional HR induction and capacity building. Likewise, new regional population houses and regional training institutes will also be constructed to further strengthen the services offered by population welfare department

Measures will be adopted to improve and strengthen referral linkages and feedback mechanism between various cadres of community health workers and health care referral facilities by ensuring

supervisory visit of LHS/LHV and monthly meetings at referral units. The referral slips, record keeping formats and network will be developed and displayed in CMWs birth station, LHWs health house and health facility. The CMWs and LHWs will receive orientation on referral pathways and will also be provided with referral slips and record keeping formats.

Implementation of an integrated DHIS dash board incorporating IRMNCAH&N indicators will enhance oversight and coordination between regional and Agency management levels and procurement units and ensure continued availability of services and supplies. A multi-sectoral approach will be adopted to achieve improved coordination between the nutrition and MNCH program and other complimentary public service structures such as PHED, Agriculture, Local Government as well as social welfare department for effective planning and utilization of resources. Management and oversight of the activities of the RMNCAH&N action plan will be achieved through the implementation of an M&E framework, supported by development of plans, ToRs, reporting formats and checklists. Field supervisory tiers will be strengthened and supported at multiple administrative levels. The supervisory staff will be provided mobility and supplies as well as appropriate training for the monitoring protocols and reporting procedures.

Comprehensive family planning services will be offered which include conventional and modern methods as well as male and female contraceptive surgery facilities in static units and in extension service camps under safe and sterile circumstance. Regular means of transportation will be ensured for contraceptive procurement, distribution and provision from FATA to Agency to service delivery level. In order to confirm the availability of contraceptives at service delivery point, even outsourcing of distribution mechanisms at various levels can be taken into account.

Governance, oversight and accountability will be achieved through implementation of investigative and response mechanisms (MPDSR), development and implementation of accountability frameworks such as the oversight committee on IRMNCAH&N and the Commission on Information and Accountability for Women & Children's health (CoIA), development and implementation of quality assurance tools (KPIs) and protocols as well as developing and linking of the M&E tools to these frameworks. Capacity building of various cadres of the health staff on these protocols will be an essential part of the strategy. Regular awareness, advocacy and orientation of the politicians and parliamentarians on the one hand and demand creation at the community level will support the effective streamlining of RMNCAH&N strategy as a priority agenda in achieving the SDG goals.

The use of new technologies i.e. GIS, CLMIS, smart phone apps for EPI, m-Health and smart phones for data recording and reporting will be utilized for analysis and decision making. Research will also be carried out; encompassing the issues such as malnutrition, effective utilization of MNCH services, anemia, newborn care, CMWs, LHWs services and utilization, etc. to aid in evidence-based decision making, policy formulation, planning and consequent advocacy.

5: Social mobilization

Advocacy seminars, symposium, conferences and orientation sessions will be organized to raise awareness regarding RMNCAH&N interventions at FATA and Agency level. The internationally recognized days, such as; midwifery day, world health day, mother's day, children day, hepatitis, TB, HIV, etc. will be celebrated to emphasize and highlight the importance of various aspects and lifestyles affecting health.

The health education interventions will enable the mothers to understand that how their health seeking behaviors can promote health and well-being of the newborn and children with simple accessible and affordable interventions.

Volunteers and peer support groups will be involved for demand creation by engaging community based organizations, community elders, local influential, professionals, religious leaders, etc.

6: Monitoring & Supervision:

Monitoring and supervision ToRs, plans, reporting formats and checklists will be developed at FATA, Agency and facility level. The monitoring and evaluation framework will be endorsed at various supervisory tiers at various levels including; FATA, divisional, Agency through deputy directors at DGHS office, FATA coordinators, divisional directors, Agency team and health care facility teams.

Coordination, program management, improving data quality, data routine monitoring & reporting, and oversight will be an integral component for improved monitoring system.

OUTLINE OF MONITORING & EVALUATION PLAN

This section provides an outline of the monitoring and evaluation plan for the RMNCAH & N strategy implementation. A detailed M&E framework will be developed for tracking progress of the activities during 2016 to 2020 in Pakistan. This framework will clearly define the baselines, targets, data sources, frequency of data collection and responsibility. As part of the M&E plan, both qualitative and quantitative indicators will be added and multiple data sources will be used to provide strategic information and guidance for RMNCAH & N monitoring and evaluation plans. The overall responsibility of M&E will rest with the FATA Department of Health whereas relevant vertical programs will be responsible for compiling their respective M&E reports on quarterly basis and submit regularly to the DOH to be consolidated on annual basis. The DOH will be developing monitoring tools based on quality benchmarks and ensure regular field monitoring of all the activities. In addition, information from all available surveys and studies will also be used to inform the M&E plan. Using the regularly updated M&E reports, an action plan tracker will be maintained. This tracker will be regularly reviewed in annual progress review meetings to follow the progress and agree on course correction as well as follow up on agreed action from previous meetings.

The following table presents a list of core indicators for measuring the progress in achieving the key objectives of the strategy.

Table 2: Strategic objectives with key indicators of achievement.

Strategic Objectives	Core Indicators of achievement
Objective1: Improving access and quality of IRMNCAH primary care community based services ensuring continuum of care including newborn care in rural Agencys and urban slums	- % coverage of target districts with IRMNCAH&N services by LHWs and CMWs. - % of CMWs and LHWs involved in routine immunization. - % increase in uptake of IRMNCAH&N services from CMWs and LHWs. -
Objective 2: Improved quality of care at primary & secondary level care facilities.	- % of HCF in target districts with full complement of HR, supplies and functional infrastructure for IRMNCAH&N services including referral mechanisms. - % of HCF with health care providers trained on key IRMNCAH&N topics (PCPNC, IMNCI etc). - % of HCF in target districts implementing the WHO Quality of Care standards for IRMNCAH&N services. -

Objective 3: Overcoming financial barriers to care seeking and uptake of interventions.	- % of institutions implementing new social security regulations to develop linkages between various public sector institutions for social security. - % of coverage of beneficiary population under the conditional cash transfer schemes -
Objective 4: Increase in funding and allocation for advocacy, awareness and research for RMNCAH & Nutrition	- % increase in annual funding for RMNCAH and Nutrition programs by Government of Sindh. - % of Awareness campaigns and programs conducted - % utilization of funds designated for advocacy, awareness and research activities in target districts.
Objective 5: Improve reproductive health including family planning.	- % of HCF with required supplies and appropriately trained HR for management and outreach of RH services. - % of CMWs; with enhanced skills and competencies, involved in family planning
Objective 6: Investing in nutrition especially of adolescent girls, pregnant and lactating women, children under 5	- % of HCF providing nutrition specific services (static and outreach) to MAM and SAM children, adolescent girls and PLWs in target districts. - % of districts regularly conducting supervision, monitoring and evaluation of IRMNCAH&N interventions and sharing quarterly reports at provincial level. - % of total population of adolescent girls, PLWs, MAM and normal children, provided with micronutrients -
Objective 7: Investing in addressing social determinants of health.	- % of districts adopting multi-sectorial approach for addressing social determinants of poor RMNCAH&N - Regulation formulated and implemented for mandatory female enrollment in schools.
Objective 8: Measurement and action at Agency level.	- % of districts with Integrated DHIS i.e. includes all RMNCAH & Nutrition indicators% of districts with required supplies, appropriate trained HR implementing integrated DHIS - % of districts implementing MNDSR protocols in target districts
Objective 9: National accountability and oversight.	- % of planned quarterly progress review meetings of the National IRMNCAH&N program oversight committee conducted per year - % of districts implementing the accountability framework related to IRMNCAH&N program.

Objective 10: Generation of political will to support MNCH as a key priority within sustainable development goals.	- ToRs for SDG Cell approved and cell established under P & D and DGHS -

FINANCIAL ACTION PLAN

Background and Costing Methodology

In order to operationalize the ten priority RMNCAH&N actions into concrete action plans that would enable implementation over the coming five years (2016-2020), the action plans need to be costed to serve the purpose of advocacy, resource mobilization, and providing guidance in implementation

The exercise was built upon the existing costed IRMNCAH&N action plans, which had documented the baselines where available, and clearly set targets with milestones over the 5 years duration. In circumstances where additional information required, the consultant referred to the concerned FATA and federating areas program managers. To initiate the process, inception meetings were held with the Ministry of National Health Services Regulation and Coordination, and with World Health Organization team, to discuss and approve the costing tool template. The costing tool template was discussed in detail and approved by the WHO and the MoNHSR&C.

The costing tool utilized in this process was a simplified costing developed in Microsoft Excel. The tool comprises 11 sheets (one for each of the 10 objectives in alignment to the ten objectives of the strategy, and one for overall summary). The tool was prepared in a way to calculate the total cost per activity, required for implementation of the activity/intervention each year, and summed up to provide the total cost per activity required for five years along with the available resources with funding sources and the funding gap.

The MNCH program FATA took the lead and facilitated/coordinated the process of costing of RMNCAH and Nutrition action plan. A tentative costing done by the consultant was shared with the MNCH program for the review and inputs by the relevant stakeholders. In the light of feedback received from the MNCH program, the revisions/modification were made. The unit costs were determined on the basis of unit costs finalized for Sindh, Punjab, Balochistan and Khyber Pakhtunkhwa and available documents like RMNCAH&N action plan of FATA, PC-1s, Comprehensive Multi-Year Plans of EPI, project concept notes, etc. The number of units were mainly taken from the RMNCAH&N action plan. Where necessary, the number of units has been changed for some of the activities, as suggested by the MNCH program during the costing process. In consultation with the concerned stakeholders, an inflationary increment of 10% every year was applied to the unit costs, due to a periodic increase in the prices of goods and services.

DETAILS ON RESOURCE REQUIREMENTS

The already developed RMNCAH and Nutrition action plan has been costed under the ten priority objectives, using the costing tool, especially developed for this task. For each objective, corresponding activities have been costed.

Component-wise total resource requirements

1 Resource requirements by component/ objective

S.#	Component/Objective	Total PKR	%
1	Improving Access and Quality of MNCH Community Based Primary Care Services	5,730,423,115	47.27
2	Improved quality of care at primary and secondary level care facilities	1,302,183,000	10.74
3	Overcoming financial barriers to care seeking and uptake of interventions	1,545,000,000	12.74
4	Increased Funding and allocation for MNCH	8,550,000	0.07
5	Reproductive health including Family planning	2,200,000	0.02
6	Investing in nutrition especially of adolescent girls , mothers and children	3,198,456,682	26.38
7	Investing in addressing social determinants of health	13,800,000	0.11
8	Measurement and action at Agency level	309,798,000	2.56
9	National Accountability and Oversight	11,400,000	0.09
10	Generation of the political will to support MNCH	2,000,000	0.02
Total		**12,123,810,797**	**100**

As shown in the above table, total amount of PKR 12,123,810,797 will be required over a period of five years (2016-2020) for implementing the RMNCAH plan in Federally Administered Tribal Area. The figures generated by the costing tool also reflect the proportionate allocation for each of the ten objectives. Maximum funds (47.27%) have been costed under objective 1 i-e “Improving Access and Quality of MNCH Community Based Primary Care Services”. After this, the majority of funds (26.38%) and (12.74%) have been costed under objectives 6 & 3 respectively. The objective 6 is focusing on “Investing in nutrition especially of adolescent girls, mothers and children, and objective 3 will overcome financial barriers to care seeking and uptake of interventions in FATA.

COMPONENT-WISE YEARLY RESOURCE REQUIREMENTS

2 Yearly resource requirements by component/obejctive

S.#	Component/ Objective	2016	2017	2018	2019	2020
		PKR	PKR	PKR	PKR	PKR
1.	Improving Access and Quality of MNCH Community Based Primary Care Services	235,944,000	913,786,555	1,459,168,860	1,442,463,100	1,679,060,600
2.	Improved quality of care at primary and secondary level care facilities	148,800,000	401,445,000	247,272,000	244,868,000	259,798,000
3.	Overcoming financial barriers to care seeking and uptake of interventions	257,500,000	283,250,000	309,000,000	334,750,000	360,500,000
4.	Increased Funding and allocation for MNCH	1,050,000	1,650,000	1,800,000	1,950,000	2,100,000
5.	Reproductive health including Family planning	200,000	440,000	480,000	520,000	560,000
6.	Investing in nutrition especially of adolescent girls , mothers and children	558,419,455	592,805,611	615,220,555	681,505,683	750,505,377
7.	Investing in addressing social determinants of health	2,800,000	2,420,000	2,640,000	2,860,000	3,080,000
8.	Measurement and action at Agency level	100,360,000	75,878,000	51,600,000	55,640,000	26,320,000
9.	National Accountability and Oversight	8,400,000	660,000	720,000	780,000	840,000
10.	Generation of the political will to support MNCH	1,000,000	220,000	240,000	260,000	280,000
Total		**1,314,473,455**	**2,272,555,166**	**2,688,141,415**	**2,765,596,783**	**3,083,043,977**

Yearly resource requirements by each of 10 components/ objectives are given in the above table. Yearly resources requirement has some variation in the cost from year 1 to 5. This may be due to the i) different activities and or change in number of units during various years.

FINANCING AND FUNDING GAP

Component-wise Funding Gap

3 Funding Gap

S.#	Component/ Objective	Total Cost	Available Funds	Funding Gap	Funding Gap %
		PKR	PKR	PKR	
1.	Improving Access and Quality of MNCH Community Based Primary Care Services	5,730,423,115	490,550,000	5,239,873,115	91.44
2.	Improved quality of care at primary and secondary level care facilities	1,302,183,000	127,200,000	1,174,983,000	90.23
3.	Overcoming financial barriers to care seeking and uptake of interventions	1,545,000,000	3,600,000	1,541,400,000	99.77
4.	Increased funding and allocation for MNCH	8,550,000	500,000	8,050,000	94.15
5.	Reproductive health including Family planning	2,200,000	500,000	1,700,000	77.27
6.	Investing in nutrition especially of adolescent girls , mothers and children	3,198,456,682	225,200,000	2,973,256,682	92.96
7.	Investing in addressing social determinants of health	13,800,000	0	13,800,000	100.00
8.	Measurement and action at Agency level	309,798,000	23,700,000	286,098,000	92.35
9.	National Accountability and Oversight	11,400,000	1,100,000	10,300,000	90.35
10.	Generation of the political will to support MNCH	2,000,000	0	2,000,000	100.00
Total		**12,123,810,797**	**872,350,000**	**11,251,460,797**	**92.80**

As seen in the above table, the available funding is approximately 7% of the total resource requirement for implementing RMNCAH plan. Mainly, these funds will be provided by the FATA Secretariat. The remaining 93% of the total resources requirement is a funding gap, for which Government of FATA will mobilize resources through allocating funds from their own budget, and by approaching potential donors through the MoNHSR&C.

FATA ACTION PLAN FOR IRMNCAH&N STRATEGY

Action Plan FATA for National RMNCH & Nutrition Strategy 2016-

Activities	Indicators		Target by year					Responsibility
			2016	2017	2018	2019	2020	
Objective 1: Improving access and quality of MNCH community based primary care services ensuring continuum of care including newborn care in rural districts and urban slums								
Expected outcome 1.1: improved, access, coverage & utilization of quality RMNCAH and Nutrition services through community based workers (LHWs and CMWs) in the targeted Agencies	**50% coverage (subject to** **Baseline**	**Target**						
1.1.1 Mapping of outreach staf (CMWs,FMWs, MMWs, vaccinators, LHWs) **Partial	NA	100%		6 Agencies	6 FRs			
1.1.2 Recruitment of outreach staf (CMWs,FMWs, MMWs, vaccinators, LHWs 1379) **	CMWs 123, Vaccinator /EPI technician 248 ,LHWs 1379 , FWWs 54 , MSMs 0	CMWs 1100, Vaccinator/EPI Tecnician 250, LHWs 3300 , FWWs 50,MSMs	CMWs 150	CMWs 237, Vaccinator/ EPI Tecnician 125, LHWs 825 , FWWs 17 ,MSMs 163	CMWs 237, Vaccinator/ EPI Tecnician 125 , LHWs 825 , FWWs 17 ,MSMs 163	CMWs 237, Vaccinator/ EPI Tecnician , LHWs 825 , FWWs 16 ,MSMs 163	CMWs 237, Vaccinator/ EPI Tecnician , LHWs 825 , FWWs ,MSMs 162	MNCH Program/National Program/EPI/P WD
1.1.3 Training of more outreach workers from uncovered areas as per mapping	CMWs 123, Vaccinator /EPI technician 248 ,LHWs 1379 , FWWs 54 , MSMs 0	CMWs 1100, Vaccinator/EPI Tecnician 250, LHWs 3300 , FWWs 50,MSMs	CMWs 150	CMWs 237, Vaccinator/ EPI Tecnician 125, LHWs 825 , FWWs 17 ,MSMs 163	CMWs 237, Vaccinator/ EPI Tecnician 125 , LHWs 825 , FWWs 17 ,MSMs 163	CMWs 237, Vaccinator/ EPI Tecnician , LHWs 825 , FWWs 16 ,MSMs 163	CMWs 237, Vaccinator/ EPI Tecnician , LHWs 825 , FWWs ,MSMs 162	MNCH Program/National Program/EPI/P WD
1.1.4.Trainings on Standard Clinical outlook, procedure and Record keeping 50 WMOs, 1141 FWWs/FWC/FTO over 5 years	7 WMOs, 54 FWWs,LH Vs 370,	25 WMOs, 370 LHVs, 54 FWWs, 260 Nurses	WMOs, LHVs, FWWs,Nurse s	10 WMOs, 93 LHVs, 14 FWWs,65 Nurses	10 WMOs, 93 LHVs, 14 FWWs,65 Nurses	5 WMOs, 93 LHVs, 13 FWWs,65 Nurses	93 LHVs, 13 FWWs,65 Nurses	MNCH Program/National Program/EPI/P WD
1.1.5. Training of Officers (Field & Provincial) on Monitoring & Supervision (total 120)	33 LHSs, 3 FPOs from LHW,3 Technical Supervisor s from MNCH Office, Program Total 70 (4 Officer /Agency/ FRs,15 from Provincial Office)	33 LHSs, 3 FPOs from LHW,3 Technical Supervisors from MNCH Office, Program Total 70 (4 Officer /Agency/FRs,15 from Provincial Office)	0	50 % in 2017	50 % in 2018			DHS/MNCH Program/National Program/EPI/P WD

1.1.6. Capicity Building of the HCP of Directorate of Health & PWD in Long Acting Reversible Contraceptives(180 WMO/Mos & 180 FWW/LHVs)	5 WMOs,260 Nurses,370 LHVs	27 WMOs, 260 Nurse, 370 LHVs	0	27 WMOs (in 2 Batches), 250 Nurse/ LHVs (in 10	250 Nurse/ LHVs (in 10 Batches)	130 Nurse/ LHVs (in 5 Batches)		DHS/PWD
1.1.7. Construction of Warehouse 5000 sq. ft. with all allied facilities	0	7	Assessment of existing infrastructure warehouses (Based on result maximum of 7 may be constructed and expension where required)	25%	50%	25%	0	DHS /PWD (provision of space for PWD)
1.1.8. Provision of Solar Pannels with inverter for insertion lamps for Insertion rooms of Fw center/ RHCs/ BHUs and AHQs	0 Fw center/ RHCs/ BHUs and AHQs	50 FW center/ 11 RHCs/ 173 BHUs /4 THQs/7AHQs/5 Type D Hospitals /23 CH/206 CHCs/77 MCH Centers (100 New Health Facilties will be Operationalized Soon)	Assessment of all Health Facilities	Procurement	100%			DHS/PWD
1.1.9. Strengthening of RTIs through hiring of tutors including Qualified in English Subject	No RTI in FATA	NA	NA	NA	NA	NA	NA	
1.1.10. Strengthening of RTIs through Provision of Teaching Aids (Dummies, Menniquin, Demonstration material, multimedia , desk compurters, scanner, lap top etc)	No RTI in FATA	NA	NA	NA	NA	NA	NA	
1.1.11. Replacement/Provision of Equipments to Service Delivery Project (IUCD kits, Cheatle forceps, drums etc and UV light)	61 Outlets	61 outlets		Replacement of equipments in all 61 outlets				DHS/PWD
1.1.12. Furnishing Hall (for training purpose/ seminars) with all allied facilities. One time activity	0	1	0	1				PWD
1.1.13.Upgrading FWC, RHSAs & MSUs to Model Units	50 FWC, 4 RHSAs & 7 MSUs to	50 FWC, 4 RHSAs & 7 MSUs to Model Units	Assessment	50%	50%	0	0	PWD
1.1.14. Provision of UV lights for 4 RHSAs & 7 MSUs	0	4 RHSAs & 7 MSUs	0	4 RHSAs & 7 MSUs	0	0	0	PWD
1.1.15. Repair, Renovation of 4 RHSAs	4 RHSAs	4 RHSAs	0	2	2	0	0	PWD
1.1.16.Printing of Counselling Material on FP	0	1000	0	1000	0	0	0	PWD
1.1.17. Establishment of midwifery schools with in FATA)	0	3 (Khyber, Bajaur, South Waziristan)	0	Paper work completed	3	0	0	DHS/MNCH Program

1.1.16.Printing of Counselling Material on FP	0	1000	0	1000	0	0	0	PWD
1.1.17. Establishment of midwifery schools with in FATA)	0	3 (Khyber, Bajaur, South Waziristan)	0	Paper work completed	3	0	0	DHS/MNCH Program
1.1.18. Recruitment and Hiring of qualified midwifery tutors	3	6	0	0	6	0	0	DHS/MNCH Program
1.1.19. Recruitment and hiring for MNCH Program (MIS, HR , Midwifery advisor,admin, procurement, training coordinator)	0	6	0	0	6	0	0	DHS/MNCH Program
1.1.21. Recruitment of clinical/Midwifery Supervisors / LHVs /Nurses 2 per agency + 7 FRs	0	20	0	0	20	0	0	DHS/MNCH Program
1.1.22. Increase the stipend for CMWs	3500	7000	increase in stippened (if) any Govt policy					
Incraese the incentive for the deployed CMWs	2000	5000						
1.1.28 Enrollment of Religious Scholars as Social Mobilisers at Sub Tehsil Level	0	100	0	50	50	0	0	DHS/MNCH Program/PWD/LHW/EPI/Nutrition
1.1.29. Establishment of FATA Health and Population Research Institute	0	1	0	0	1	0	0	DHS/MNCH Program/PWD/LHW/EPI/Nutrition
Expected outcome 1.2: Improved quality of community based RMNCAH and Nutrition services (through improvement in monitoring and supervsion/revision of ToRs/capacity buidling and supplies)	**Baseline**	**Target**						
1.2.1 Capacity Building of existing CMWs (refresher courses/short term) Duration One Month	123	123 deployed + 100 waiting for deployment	23	100	100	0	0	MNCH Program
1.2.2 Increase capacity of existing CMW tutors by enhancing technical/clinical skills	3	3	3	0	0	0	0	MNCH Program
1.2.3 Recruitment of LHSs/Drivers/ LHV (CMWs supervisory staff) for supervision and monitoring	33	165 (1 LHS/20 LHWs and 165 Drivers)	0	42 LHSs every Year	41 LHSs every Year	41 LHSs every Year	41 LHSs every Year	LHW Program
1.2.4 Training of LHS/ LHV for supervision	0	165 LHSs + 77 LHVs		42 LHSs + 20 LHVs every Year	41 LHSs + 20 LHVs every Year	41 LHSs + 20 LHVs every Year	41 LHSs + 17 LHVs every Year	LHW Program
1.2.5 Refresher trainings of LHVs/LHSs on technical monitoring (in facility and field) of CMWs	33 LHSs + 0 Technical Supervisor	33 LHSs	Training by End of November 2016	0	0	0	0	MNCH/LHW Program
1.2.6 (a) Increase in mobility support to the supervisory staff LHS (b) Increase in mobility support to the supervisory staff LHV	33	165	0	42	41	41	41	LHW Program
1.2.7a, Integrated monitoring and supervision plan/rosters for LHSs and LHVs to monitor LHWs and CMWs at the catchment area. B, LHS/ LHV supervised by APIU Field prog officer/ PIU officers with facility	integrated supervision plan		integrated 22 visits by LHSs/ Month= 240	240	240	240	240	LHW Program LHWs/MNCH Program
1.2.8 Enhancement of skills of CMWs focusing on clinical (hands on), mendatory roaster for shift duties **(pre service)**	As per plan	As per plan	As per plan	As per plan	As per plan	As per plan	As per plan	MNCH Program
1.2.9 Refresher trainings of CMWs on maternal (5 Days Training), newborn care (5 Days Training), FP (5 Days Training), nutrition (5 Days Training) and In-service training of CMWs on new areas (HTSP, IYCF, ENC, HBB, Use of Chlorhexidine and misoprostol, cIMNCI (11 Days Training)	223	223	4 trainings each component	12 trainings each component/ Year	12 trainings each component/ Year		0	MNCH Program

1.2.12 Provision of logisitics for cIMNCI, nutrition and contrceptives to the CMWs	0	100%	As per provision	As per provision	As per provision	As per provision	As per provision	
Expected outcome 1.3: Improved community routine immunization through involvement of vaccinators with coordination of LHWs/ catchment area	**Routine Immunization coverage by LHWs in LHWs**		**70%**	**75%**	**80%**	**85%**	**90%**	**EPI Program**
	Baseline	**target**						**EPI Program**
1.3.1 Training/ awareness of LHWs on Routine immunization and referral	0%	100%	0					EPI Program
1.3.2 Coordination among Vaccinator and LHWs in routine immunization activities through proper micro planning at catchment area level	**All facilities linked through referral system**		100%	100%	100%	100%	100%	EPI Program/LHW Program
Expected outcome 1.4: Improved linkages (referral) between the LHWs/CMWs and HCFs for Nutrition/FP/ANC/Natal care/PNC/SBA/EPI/NBC	**Baseline**	**Target**						
	Fragmented	**Integrated and in place**						
1.4.1 Development of referral network/ Agencies and MDSR	not in place	Developed and displayed		100%	100%	100%	100%	All concerned program and HFs
1.4.1a. Notification of Committee of all concerened Programs to developed linkages network			Notification will be done in by end of 2016	Will be Developed in 2017				
1.4.2 Orientation to LHWs, CMWs and HCF staff on referal pathways	0	100%		50%	50%			All concerned program and HFs
1.4.4 Development/printing/provision of referral slips and record keeping formats to the CMWs and LHWs	0	100%		100%				MNCH and LHW Programs
1.4.3 Display of referal linkages pathways in CMWs birth stations, LHWs Health Houses and Health Care facilities	0	100%		50%	50%			All concerned program and HFs
1.4.5 Strengthening linkage between referral unit/LHS/ LHW/ CMW by ensuring supervisory visit of LHS and monthly meeting at Refferal unit.	0	100%		22 visits by LHSs/ Month= 240	22 visits by LHSs/ Month= 240	22 visits by LHSs/ Month= 240	22 visits by LHSs/ Month= 240	
Expected outcome 1.5: Increase in community demand for RMNCAH and Nutrition services	**% of ANC coverage**							
	Baseline	**Target**						
	73% (PDHS 12-13)	**90%**						**PPHI/ MCHIP**
1.5.1. Awareeness and Advocacy Campaign (Communication Strategy)	1	1 (Need revision with Integration of all Programs)	1	1	0	0	0	DHS/MNCH Program/PWD/LHW/EPI/Nutrition
1.5.2 Utilization of social mobilizers/support groups/ CBOs for community mobilization and health services awareness on RMNCH and Nutrition	0	20	Coordination Meeting of All CBOs/NGOs working in FATA	Quarterly Meeting	Quarterly Meeting	Quarterly Meeting	Quarterly Meeting	MNCH/ LHW
1.5.3 Conduct effective health education and awareness sessions at community (LHWs/CMWs/Health staff) in the catchment area of the HCF	Inadequate	100%	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	MNCH/LHW Program

1.5.3 Conduct effective health education and awareness sessions at community (LHWs/CMWs/Health staff) in the catchment area of the HCF	Inadequate	100%	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	Once a month in LHWs/ CMWs area	MNCH/LHW Program
1.5.4 involment of community elders, relegious leaders, print and eloctronic media for BCC on RMNCH and Nutrition **(specific days & week)**	Inadequate	Strengthen	100%	100%	100%	100%	100%	MNCH/LHW/Nutrition Program
1.5.5 Provision of E- communication IEC material on MNCH, FP and Nutrition to CMWs for health educations sessions	0	100%		To be developed in 2017	100 % Available	100 % Available	100 % Available	MNCH Program
Objective 2: Improve access to and quality of RMNCH care at Primary and Secondary level care facilities								
Expected outcome 2.1 : Enhanced skills of HCPs on IMNCI/PCPNC/ENC/HBB/NBC/ RH/ CMAM/ IYCF etc (training package) at Primary and Secodnary HCFs	**75% of the HCPs at PHC are trained on**							
	Baseline	**Target**						
2.1.1. Capacity building of **Newly inducted** health care providers at PHC facilities (Pediatrcians/MOs/WMOs/MTs/Paramedics etc) on IMNCI skills	0	67 + 57 New MOs, 85 HCPs in Category D Hospitals and 75 for Newly inducted HCPs of Category D Hsopital = 284		4 Batches in 2017	6 Batches in 2018	2 Batches in 2019	0	DHS /MNCH Program
2.1.2 Create pool of IMNCI facilitators in FATA	8	16		16	24	24	24	DHS /MNCH Program
2.1.3 Conduct follow-up visits 4 – 6 weeks after IMNCI training (2nd part of training) for the trained providers for all components.	0	100%		100%	100%	100%	100%	MNCH Program
2.1.4 Conduct training of Health care provides (Gynecologists/Obstetricians/WMOs/LHVs/MW Nurses) on PCPNC	47						0	MNCH Program
2.1.5 Create pool of PCPNC facilitators in FATA (11-14 Days Training)	0	18	18 (WHO)				0	WHO
2.1.6 Conduct training of the HCPs (Gyne &Obs, WMO, MO, Pediatricians, LHVs, staff nurses) on Essential Newborn Care (ENC) (5 Days training)		100%					0	WHO/UNICEF
2.1.7 Increase the pool of ENC facilitators at FATA level	0	18	18	0	0	0	0	MNCH Program
Conduct training of the HCPs (Gyne/Obs, LMO, MO, Pediatricians, LHVs, staff nurses) on CMAM/ IYCF								Nut/ MNCH Program
2.1.9 Conduct the training of HCPs (Pediatrician/ MO/WMO/Staff Nurses) on inpatient neonatal care.	7	30	25%	75%			0	WH0/UNICEF
Expected outcome 2.2: Strenthened Health systems for RMNCAH/Nutrition services through filling the HR gaps, repair/renovation/upgradation of HCFs and provision of supplies	**Availibility of 24/7 cEMONC**							
	Baseline	**Target**						
2.2.1 Provision of essential IMNCI/PCPNC/ENC equipment to all DHQ/THQ/RHCs for establishment of under 5 and Basic EMOC clinics	patchy	100%	Assessment of all Health Facilities for Equipments through Checklist	100%	100%	100%	100%	DHS/MNCH Program/UNICEF
2.2.2 Provision of essential IMNCI/PCPNC/ENC drugs to all DHQ/THQ/RHCs and their inclusion in routine Drug list	patchy	100%	Assessment of all Health Facilities for drug list through Checklist	100%	100%	100%	100%	DHS/MNCH Program/UNICEF

2.2.3 Establish sick newborn care units through provision of equipment and supplies at AHQs	0	2 under Process & 3 New will be establish	2	3				DHS/MNCH Program
2.2.4 Induction of HR for providing 24/7 CEmONC services at AHQ/THQ and Basic EMONC services at RHCs.as per requirement (gynecologist, pediatrician, anesthetist, WMOs, Nurses, LHVs,OTT, BBT, Lab tech,aya, sweepers)	patchy	100%	40%	60%				DHS/MNCH Program
2.2.6 Renovation/repair of CMWs School and hostels	3 Under administration of KP Govt need renovation of that	3	3	3				MNCH Programme
Expected outcome 2.3: Improved referral mechanism involving all health care levels to ensure continuum of care	**All level health care facilities**							
	Baseline	**Target**						
2.3.1a. Provision of ambulances to HCFs for referral of cases.		**4**			4			DHS
2.3.1b. Repair & Maintanace of Ambulances		**24**		24				DHS
2.3.2 Establish Web based data base at AHQ/THQ/RHCs/CH/Category D	0	49 (6 AHQ/11 THQ/11 RHCs/23 CH/5 Category D)		49				DHS
2.3.3 Provision of IT support to establish referral desks and data base	0	49 (6 AHQ/11 THQ/11 RHCs/23 CH/5 Category D)		49				DHS
2.3.4 Training of the HCPs on maternal and child health referral data recording and dissemination	0	49 (6 AHQ/11 THQ/11 RHCs/23 CH/5 Category D)		49				DHS
Expected outcome 2.4: Improved monitoring and supervsion of the facility based RMNCAH and Nutrition services	**% Health facilities that received at least one**							
	Baseline	**Target**	440	440	440	440	440	DHS
2.4.1 Develop/strengthen M&E/supervisory tiers at various level.	4 tiers	4 tiers						DHS
2.4.2 Develop/strengthen provincial, Agency and facility level M&E supervsion plans, ToRs and reporting formats/Checklists	Inadequate	Needs Revision	Tools will be developed	100%	100%	100%	100%	DHS
2.4.3 Capacity buidling of the M&E and supervsiory tiers on M&E tools	0	All tiers		100% Training				DHS
2.4.4 Review of the M&E feedback reports and reccomendation.	nil	to be implemented		100%	100%	100%	100%	DHS
2..6 Availibility of comprehensive quality EPI services as part of RMNCAH/Nutirtion services package at all PHC level facilities	**Increase in EPI coverage in**		48	57	67	75	85	
	Baseline	**Target**						EPI Program
2.6.1 Ensuring required resources for EPI programme as per PC1 and cMYP	500	500	0	500				EPI Program
2.6.2 Provision of solar ILRs to all PHC facilities							0	EPI Program
2.6.3 Ensuring timely availability of EPI vaccines as per updated schedule	<80%	100%	100%	100%	100%	100%	100%	EPI Program
2.6.4 Periodic review of EPI performance at various levels	2	172	34	34	34	34	34	EPI Program
2.6.5 Development of the training plan and Refresher trainings of the staff	0	550	110	110	110	110	110	EPI Program
2.6.6 Monitoring and supervision and mobility support	42%	100%	2.3 million US	1.7 million US	0.71 million US	0.77 million US	0.83 million US	EPI Program

Objective 3: Overcoming financial barriers to care seeking and uptake of interventions								
	Establishment of							
	Baseline	**Target**						
3.1.1. Conditional Cash transfer for EPI and Nutrition	**0**	**Pilot in 2 Low Performing (Low EPI Coverage) Agencies**		**100%**	**100%**			
3.1.2.Prime Minister National Health Program	**0**	**2 (Khyber and Bajaur)**		**100%**				
	PMU provincial & PMU in Districts, Inrollment under							
	Baseline	**Target**						
	pilot in 4 districts							DoH
Objective 4: Increase in funding and allocation for RMNCAH								
Expected outcome 4.1: Increased resource allocation and mobilization for RMNCAH and Nutrition Programs	**Increase in the government**							
	Baseline	**Target**						
	0	**100%**						
4.1.1.Establish Coordination Committee & conduct Quarterly Meetings of Coordination Committee of all Stake Holders	0	18 Meetings	2	4	4	4	4	
4.1.2.Bi annual advocacy/Consultative Meetings with stakeholders and partners on Financial & Implementation Strategy	0	9 Meetings	1	2	2	2	2	
Expected outcome 4.2: Improve in mechanism and capacity of the FATA to absorb and utilize the available resources	**Timely release of the funds to**							
	Baseline	**Target**						
	0	**100%**						
4.3.1 Development of the annual budgeted workplans for the RMNCAH/EPI/LHW/Nutrition Programs for timely implementation	Already in place	Continue						DHS
4.3.2 Capacity buidling of the DDOs and their Account Officers on efficient uitlization of available funds, monitoring of resources and audits	0	25 (one batch)		100%				DHS
Objective 5: Improve Reproductive Health including family Planning								
Expected Outcomes 5.1: Enhanced coordination of Population Welfare and Health department and functional intergartion of RH/FP and RMNCAH sevices at HCF level	**Integration of the FP and**							
	Baseline	**Target**						
		100%						
5.1.1 Quarterly Meeting of steering committee for Health & Population Welfare to oversight/review for better coordination in planning, procurements and service delivery (health mnagement committee)	0	18 Meetings	2	4	4	4	4	DHS

Objective 6: Investing in nutrition especially of adolescent girls, mother and children								
Expected Outcome 6.1: Improved infant and young child nutrition (children < 24 months) practices in all Agencies (7) and FRs (6) of FATA	**% increase in coverage of**							**FATA Nutrition Cell**
	Baseline	**Target**						
6.1.1.Annual celebration of Breast Feeding Week (August)		1 Regional & 7 Agencies & 6 FRs	1 Regional & 7 Agencies &	1 Regional & 7 Agencies &	1 Regional & 7 Agencies &	1 Regional & 7 Agencies &	1 Regional & 7 Agencies &	MNCH, LHW Program, Nutrition Program and DoH FATA
6.1.2. Notification of Regional Infant Feeding Board and conduction of Annual Meeting	0	1	1	1	1	1	1	
6.1.3. Adopt/Implement National IYCF communication Strategy	0	1	Adoption	Initaite implementation Startegy				
6.1.4. Develop & Implement Regional Nutritional Stategy	0	Strategy Developed to be implemented	Developed and Endorse	Implemented				
Expected Outcome 6.2: Reduction of micronutrient malnutrition among young children (6-59 months), School aged children (Grade 1-5), adolescent girls and	**% decrease in child,**							**FATA Nutrition Cell**
	Baseline	**Target**						
6.2.1: Provision of multiple micronutrient powder for home fortification for all children 6-59 months and Iron/Folic Acid for PLWs and adolescent girls	5 Agencies	7 Agencies + 6 FRs	include remaining 1 + continue in others	1 Agency + 3 FRs + continue in others	3 FRs + continue in others	100%	100%	DHS/LHW Program/Nutrition Program
6.2.2: Biannual deworming of all children 2-5 years of age	22% (100% coverage in LHW covered area)	>80% children (78% uncoverd area of LHW)		20% coverage through new induction of LHWs	20% coverage through new induction of LHWs	20% coverage through new induction of LHWs		
6.2.3: Biannual deworming of all primary school aged children (Grade 1-5)	0%	> 80% children (Through School Health Program)	Administaive notification Orientation of Caders + Provision of Supplies	100%	100%	100%	100%	
6.2.4. Notification of Regional Food Fortification Alliance conduction of BI Annual Meeting	1	1	1	1	1	1	1	
6.2.5: Biannual Vitamin-A supplementation with NIDs for all children < 5 years	80%	> 90% coverage	> 85% coverage	> 90% coverage	> 90% coverage	> 90% coverage	> 90% coverage	
6.2.5a: Promoting use of Iodized Salt through awarness campaign	0	18 (Seminars/Day Celebration/ Advocacy)	2	4	4	4	4	
6.2.5b.Revival of committee on IDD	1	1	Notification with ToRs					
6.2.6: Intermittent iron/folic acid (IFA) supplementation for adolescent girls	0	> 60% (adolescent girls)	Ensure provision of IFA in LHWs kit for Adolescent girls	30-35%	> 60%	> 60%	> 60%	
6.2.7.: Promotion of healthy/appropriate eating for pregnant ladies and lactating mothers including provision of supplementary food	30%	> 60% PLW	Maintain 30%	> 60%	> 60%	> 60%	> 60%	
6.2.8: Zinc supplementation for children of age 6-59 months	0	> 60% Children	Procurement of Zinc for LHW kit and Health Facilities	> 60%	> 60%	> 60%	> 60%	
6.2.9: Printing of IEC materials and Orientaion of HCPs/LHWs	0	Developing IEC	100%					

6.2.8: Zinc supplementation for children of age 6-59 months	0	> 60% Children	Procurement of Zinc for LHW kit and Health Facilities	> 60%	> 60%	> 60%	> 60%	
6.2.9: Printing of IEC materials and Orientaion of HCPs/LHWs	0	Developing IEC material	100%					
Expected Outcome 6.3: Enhanced assess of local community to life saving nutrition services for acute malnourished children in all Agencies (7) and FRs (6)	**% decrease in Global Acute**							**FATA Nutrition Cell**
	Baseline	**Target**						
6.3.1: Establishment and Fuctionalization of inpatient nutrition services (Stabilization Centers) in secondary health care facilities	5 SC	3 SC	Maintain & strengthen 5 SC	Establish 3 New SCs	100%	100%	100%	MNCH/WHO/ UNICEF/Nutrition Program and DHS FATA
6.3.2: Establishment and Fuctionalization of outpatient nutrition services (SFP and OTP Centers/Breast Feeding Corners)	100 Health Facilities	250 (SFP/OTP in each RHC (11) and in selected BHUs + FRs)	Maintain 100 functional Centers	50%	50%	100%	100%	
6.3.3. HR/Nutritionist at each Agency level and Regional level (BPS 17)	6 (1 Regional +	8 (2 Agencies + 6 FRs)	0	60%	100%	100%	100%	DHS/Nutrition Program
6.3.4. Nutrition Supplements for SFP/OTP Centers/NSC (RUSF,WSB/FBF,OIL/RUTF,F-75, F-100,ResoMal,MM Tabs,MM Sachets, Iron/Folic ACID)	160 Health Facilties	100 Health Facilities	28 Health Facilities	50	22			DHS/Nutrition Program
6.3.4a.Costing and Procurment of Nutrition Supplements (RUSF,WSB/FBF,OIL/RUTF,F-75, F-100,ResoMal,MM Tabs,MM Sachets, Iron/Folic ACID)	0	100%	100% Costing	Procurment	100% available			
6.3.5. Procurement of Equipments/Instruments for SFP/OTP Centers (Uniscale, Height/Length Board, MUAC Tapes for Children/PLWs)	160 Health Facilties	100 Health Facilities	28 Health Facilities	50	22			
6.3.5. Equipments/Instruments for NSC (Complete NSC Kit)	5 SC	3 SC	Maintain 5 SC	Provide Kits to 3 New SCs	100%	100%	100%	
objective 7: Investing in addressing in social determinants of Health								
Expected Outcome 7.1: Health Friendly Multi Sectoral Policies and Practices adopted (health, education, public health engineering, social walfare, women welfare deparments, NGOs, civil society and PPP).	**Integrated mechism to address**							
	Baseline	**Target**						
	0%	**40%**						
7.1.1.Strengthning Multi Sectoral Coordination Committee at Regional Level (Quarterly Meetings)	1	1 (18 Meetings)	2	4	4	4	4	
7.1.2. Involvement of parlimentarians, politicians/ religious leaders, human rights, teachers and other civil society through seminars/ official meetings to link their slogans and campaigns to RMNCAH/Nutrition/Mental Health issues in women, adolescent girls and children along social determinants like female literacy and economic empowerement at agency and Regional level	0	1 Meeting/Year	1	1	1	1	1	DHS
7.1.6 Establish Health/education Promotion cell in DHS and Agency level	0	7 (1/Agency) + 1 DHS	Notification with clear ToRs	Biannual Meeting	Biannual Meeting	Biannual Meeting	Biannual Meeting	DHS/AS/Education/Nutrition

Expected outcome 7.2: Laws inplace supporting mandatory female education, Birth/Death registration and marriage registration	**Laws pertaining to mendatory**							
	Baseline	**Target**						
		Laws passed						
7..2.3 Advocacy and registration of each and every birth/Death	0	1 advocacy seminar/year	1	1	1	1	1	
7..2.4 Advocacy for Female education and marriage registration	0	1 advocacy seminar/year	1	1	1	1	1	DoH
Objective 8: Measurement and action at district level								
Expected Outcome 8.1: Generation of Valid,Timely, Complete, Reliable routine Data								
8.1.1. Formulation of DHIS review committee to review exsisting system and include missing indicators on RMNCAH, Nutrition and other programs	0	1 Committee	Notify	Revision & endorsemne t for DHIS				
8.1.2. Training of Master Trainer Agency wise (DHIS)	1 Batch Trained (8 Person)	4 Batches required (10/Batch)	1	3				ADP/DHS
8.1.3a. Training of Facility staff (DHIS) (3 days)	250	750 (30 Batch 25/Batch)	0	30 Batches 3 Baches/ Agency				
8.1.3b. Refresher training of Facility staff already trained (2 Days)	0	250 + (750 after 2017)		250 (10 Batch)	250 (10 Batch)	250 (10 Batch)	250 (10 Batch)	
8.1.4 Quarterly Agency performance Review meetings on DHIS at Regional level	0	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	Quarterly review meeting	
8.1.5 Develop/Adoption of Monitoring proforma/Checklist		1 No	By end of 2016					
8.1.6 Monitoring of health facilities in regard with DHIS reporting	0	Develop Plan	As per plan	As per plan	As per plan	As per plan	As per plan	
8.1.7 Establish E-Reporting system	0	1 No		By mid 0f 2017				
8.1.8 Maintenance of new DHIS Software	0	Functional System			maintena nce	maintena nce	maintena nce	
8.1.9 Provision of Printed Material i.e DHIS Tools and instruments for routine reporting	100% availabl e	Ensure 100% availability	On going					

8.1.9 Provision of Printed Material i.e DHIS Tools and instruments for routine reporting	100% availabl e	Ensure 100% availability	On going					
8.1.10 Training for Managers at each level on use of information (5 Persons/Agency/FRs + 10 from Regional Level)	0	75 (18/Batch) 4 Batches	0	2 Batches	2 Batches			DHS
8.1.11. Equipment/Furniture required for Agency Headquarter Hospitals/Agency Sugreons and DHIS Cell DHS FATA		23 offices/DHIS cells		Available as per need				DHS
8.1.12. Adapt WHO Maternal and New Born Death Audit Guidelines, Protocols,Refrrals SOPs,Recording & Reporting Tools (2 Selected Agencies AHQ Hospitals of Bajaur and Khyber)	0	2 Agencies in FATA	1 AHQ in 2016	1 AHQ in 2017				WHO/DHS
8.1.13. One day orientation/Sensitization meetings with stake holders on Maternal and New Born death Audit (Local Councelors, Religious Leaders, Media, Teachers, Mothers Support Group etc)	0	2 Agencies in FATA	100%					WHO/DHS
8.1.14. 3 Days trainings of Health Care Providers (Gynacologist, M/F Medical Officers, LHVs, LHSs,CMWs) in Maternal and Newborn	0	26	50%	50%				WHO/DHS
8.1.15. Develop Policy brief on Maternal & Newborn Death Audit	0	100%	100%					WHO/DHS
Objective 9: National accountability and oversight								
Expected Outcome 9.1: Effective oversight mechanism of the RMNCAH/N Program in place.	**Monitoring and supervision**							
	Baseline	**Target**						
Expected Outcome 9.1. Improve Governeness and Accountibility	0							
9.1.1. Formulation of oversight Committee Chaired by Sectory Socail Sector to review Performance and outcomes (Bi Annual Meetings)	0	Formulate Oversight Committee	Formulate Oversight Committee					
9.1.2.Development of accountibility Framework	0	Frame Work Develop	Frame Work Develop					
9.1.3.Link the Monitoring and Evaluation reports for accountiblity framework	0	Quarterly Reports	Quarterly Reports					
9.1.4. Implementation of Quality assurance tools at all level	0	Development of Tools	Development of Tools					
Objective 10.Generation of the Political will to support RMNCAH & Nutrition as a key prority within sustainible develpoment goals								
Expected Outcome: 10.1. Awairness about SDGs on Health and Population among Policy Makers and Parlimentarian								
10.1.1. Establish SDG Cell under P&D FATA	0	1	Notify Committee					
10.1.2. Establish SDGs goal 2 & 3 Health Cell under DHS FATA	0	1 (Quartrly Review Meetings	Notify Cell + 1 Meeting	4	4	4	4	
10.1.3. Advocacy and Awairness oreientation of Policy Makers and Parlimentarian on Health and Population Issues	0	1 advocacy seminar/year	0	1	1	1	1	
10.1.4.Engagemnt of religiuos scholors, Media to address Myths and Misconception on Health RMNCAH & Nutrition Population Issues	0	1 advocacy seminar/year	0	1	1	1	1	